



2011
Legislative Blueprint
for Action

**Hospice Association of America
2011 Legislative Blueprint for Action**

Table of Contents

Introduction3

SECTION I: HOSPICE-SPECIFIC ITEMS

Revise Requirements for Hospice Face-to-Face Encounters5

Ensure the Full Market Basket Update for the Medicare Hospice Benefit7

Oppose Expansion of Copayments for Medicare Hospice Services8

Ensure Access to Care for Rural Hospice Patients9

Monitor Payment Revisions to Medicare Hospice Benefit10

Oppose Decreasing Hospice Reimbursement for Dually-Eligible Patients Residing
in Nursing Facilities12

Reinstate the Budget Neutrality Adjustment Factor in the Medicare Hospice Wage Index14

Provide Full Disclosure and Ensure SNF/NF Medicare Beneficiary Residents’ Right
to Choose a Hospice Provider16

Ensure Access to Medications Necessary for Pain Control17

Allow NPs to Certify Patients for Medicare Hospice Services18

Mandate Hospice Coverage Under Medicaid19

Protect Hospice Agencies from the Impact of Sequential Billing20

Oppose Imposition of Penalties for Erroneous Certification of Terminal Illness21

Support Demonstrations Allowing Concurrent Care Including Hospice and
Traditional Medicare-Covered Services22

Support Quality Assessment/Performance Improvement Program for Hospice23

Ensure the Portability of Advance Directives; Support Advance Care Planning Consultations.24

Enact Hospice-Specific Compliance Measures25

Mandate Frequency of Surveys for Medicare Hospice Benefit Providers26

Eliminate Medicare Provision Requiring Hospice Social Workers to Practice Under
the Direction of a Physician27

SECTION II: JOINT HOSPICE/HOME HEALTH ITEMS

Ensure Home Care and Hospice Participation in Transitions in Care and Other Health Care
Delivery Programs.....28

Ensure Appropriate Medicaid Rates for Home Care and Hospice.....29

Require Medical Residents and Interns to have Home Care and Hospice Experience
as Part of Their Graduate Medical Education30

Provide Sufficient Home Care and Hospice Payments so That Agencies Can Provide
Appropriate Wages and Benefits to Clinical Staff.....31

Ensure Availability of Home Care and Hospice Personnel, Particularly in Rural and Other
Underserved Areas.....32

Require Federally Funded Criminal Background Checks and Establish a
National Registry System34

Recognize Telehomecare Interactions as Bona Fide Medicare and Medicaid Services.....36

Provide Financial Assistance to Home Care and Hospice Providers to Expand
Use of Information Technologies and Implement Electronic Health Records.....38

Establish Stability and Equality Among Medicare Health Care Providers in
Application of the Wage Index.....39

Enact Home Care and Hospice Specific Anti-Fraud Measures41

HOSPICE ASSOCIATION OF AMERICA

Introduction

Hospice and palliative care services reinforce and supplement the care provided by family members and friends and encourage maximum independence of thought and functioning, while preserving human dignity. Hospice is a crucial part of humane, cost-effective care in the final stage of life. The Medicare hospice benefit was created in 1982 primarily to serve terminally-ill cancer patients. Based on this success, hospices have now greatly expanded their end-of-life care expertise to include caring for terminally ill Americans with other diagnoses such as congestive heart failure, dementia, and lung disease.

The Hospice Association of America (HAA), an affiliate of the National Association for Home Care & Hospice (NAHC), is proactively representing its members in this new and challenging environment. HAA's 2011 Legislative Blueprint for Action presents a comprehensive plan for addressing major health care initiatives facing hospice providers and reflects our agenda for the 112th Congress. The Blueprint emphasizes the increasingly important role hospice plays in the continuum of health care delivery. This publication includes our members' priorities and recommendations concerning hospice care.

The Blueprint is divided into two sections. Section I is dedicated to hospice-specific items in order of priority based on the input of HAA members. Section II contains items addressing issues of joint interest to hospice organizations and home health agencies.

This document has been produced by the Hospice Association of America, a professional association representing hospices and their thousands of caregivers who provide services to America's terminally ill patients and their families. HAA hopes this document will be helpful to Congress in its deliberations in 2011 and that it will result in the enactment of legislation to preserve the Medicare hospice benefit and improve the quality of life for the thousands of Americans who must trust others for their care and protection.

REVISE REQUIREMENTS FOR HOSPICE FACE-TO-FACE ENCOUNTERS

ISSUE: Section 3132(b) of the Affordable Care Act of 2010 requires a hospice physician or nurse practitioner (NP) to have a face-to-face encounter with every hospice patient prior to the patient's 180th-day recertification, and each subsequent recertification. The provision applies to recertifications on and after January 1, 2011.

In the Home Health Prospective Payment System Rate Update for Calendar Year (CY) 2011, the Centers for Medicare & Medicaid Services (CMS) finalized its implementation approach for this hospice provision. The final rule, codified at 42 C.F.R. 418.22(a)(4) (75 Fed. Reg. 70463, November 17, 2010) states that the encounter must occur no more than 30 calendar days prior to the start of the hospice patient's third benefit period. The regulation requires that the hospice physician or nurse practitioner attest that the encounter occurred, and the recertifying physician must include a narrative which describes how the clinical findings of the encounter support the patient's terminal prognosis of six months or less. Both the narrative and the attestation must be part of, or an addendum to, the recertification.

A number of concerns have arisen relative to the hospice face-to-face requirement:

- Hospices must complete the face-to-face encounter PRIOR TO the beginning of the applicable benefit period and must be arranged by the hospice. As the result, a patient's care may be delayed while the hospice identifies a physician or NP available and scheduled the encounter.
- The face-to-face requirement is applicable to a patient's full time on hospice regardless of when the previous hospice service was provided. A patient may have been off hospice service for a lengthy period of time then begin rapid deterioration and need admission very quickly. In such cases the face-to-face requirement may delay admission.
- Centers for Medicare & Medicaid Services (CMS) data systems are not all available 24 hours, seven days a week to access patient information and most do not have full information related to a patient's history on hospice care to establish with absolute certainty whether a face-to-face encounter is required.
- Hospices will not be reimbursed for costs related to the face-to-face requirements, which may be prohibitive – particularly for small hospices in rural areas.
- Hospices may not utilize telehealth services to meet the face-to-face requirement.
- If a patient is on continuing hospice care but the hospice is not able, due to staffing limitations or other complications, to conduct the face-to-face prior to the benefit period for which the encounter is required, the hospice will not be paid for services provided until the face-to-face has been completed.

On Dec. 23, 2010, CMS announced a three-month delay in enforcement of the face-to-face requirements due to concerns that some hospice organizations may need additional time to establish operational protocols necessary to comply with the new law. CMS indicated that it expects hospices to use the first calendar quarter of 2011 establish internal processes to ensure compliance. Beginning with the second quarter of CY 2011, hospices will have fully established such internal processes and CMS will expect appropriate documentation of the encounter.

RECOMMENDATION: Congress should revise the requirements for the hospice face-to-face requirement to allow for reimbursement of costs related to the face-to-face requirement, and provide sufficient flexibility to ensure that hospices can comply with the new law and that it will not serve as a deterrent to patients receiving timely access to services. Congress should also allow use of telehealth technologies to assist hospices in meeting the face-to-face requirement. Congress should direct CMS

to ensure that its data systems are available and contain adequate information for hospices to be able to determine with certainty whether a potential hospice patient will require a face-to-face encounter.

RATIONALE: The intent of the face-to-face requirement is to ensure adequate and appropriate involvement and accountability of physicians relative to certification of eligibility for hospice care. However, as currently written and interpreted by CMS, it may delay access to care and serve as a deterrent for some hospices to take eligible patients in need of immediate care onto service. This was neither its intent nor an advisable result of the requirement.

ENSURE THE FULL MARKET BASKET UPDATE FOR THE MEDICARE HOSPICE BENEFIT

ISSUE: The Patient Protection and Affordable Care Act (PPACA), enacted in March 2010 as Public Law 111-148, requires the development of Medicare hospice payment system reforms along the lines recommended by the Medicare Payment Advisory Commission (MedPAC) in 2009 and again in 2010 (Section 3132(a)). Under the new law, the effective date for collection of data to begin is January 1, 2011, with system reforms in operation no earlier than October 1, 2013.

P.L. 111-148 also includes interim hospice payment changes, including the institution of a productivity adjustment to the annual market basket inflation update beginning in FY2013. In addition, the final reform bill reduces the market basket index by 0.3 points for FY2013 through 2019, but conditions the 0.3 point market basket reductions in each of FY2014 – 2019 on growth in the health insurance-covered population exceeding 5 percent in the previous year.

RECOMMENDATION: Congress should restore the market basket and productivity reductions authorized under P.L. 111-148 and reject any further proposals to cut the hospice market basket update. A study of the need for refinements in the Medicare hospice benefit as recommended by the Government Accountability Office (GAO) and MedPAC should be conducted before any cuts in reimbursement are undertaken. Also, Congress should oppose any reductions in the annual updates until such time as all payment reforms are instituted and then only after the issues are fully examined.

RATIONALE:

- Beginning in FY2010, the Centers for Medicare and Medicaid Services (CMS) began phasing out by regulatory issuance the Budget Neutrality Adjustment Factor (BNAF) to the hospice wage index over seven years. It is estimated that the phase-out, when completed, will reduce hospice payments by 4 percent.
- MedPAC has projected that Medicare hospice financial margins for 2011 (without consideration of costs related to volunteer and bereavement services) will average about 4.2 percent; however, there is some concern that these estimates may not take into full account costs associated with the new face-to-face encounter requirements that went into effect Jan. 1, 2011.
- A study by Duke University showed that patients who died under the care of hospice cost the Medicare program an average of about \$2,300 less compared with those who did not. In its June 2004 report on the Medicare hospice benefit, the GAO determined that 34 percent of hospices in 2000 and 32 percent in 2001 had higher costs than reimbursements. A cut in the market basket update would impair the ability of hospices to maintain Medicare beneficiary access to care.
- The GAO recommended that CMS should collect comprehensive, patient-specific data on the utilization and cost of hospice visits and services to determine whether the hospice payment categories and methodology require modification. It did not recommend an across-the-board cut in hospice payments. CMS is in the process of collecting such data for analysis.
- At its November 2008 and subsequent meetings, MedPAC discussed potential recommended revisions to the Medicare hospice benefit reimbursement system. There is concern about the costs of short stay patients not being fully covered under the current reimbursement system. Financial margins for hospices with shorter stay patients are generally significantly lower than those of hospices serving long-stay patients. Paying accurately for all types of patients is important to ensure access to services for all Medicare beneficiaries who want to elect hospice care and to ensure that the program is paying rates that cover providers' costs for all types of patients.

OPPOSE EXPANSION OF COPAYMENTS FOR MEDICARE HOSPICE SERVICES

ISSUE: The Medicare hospice benefit was created under the Tax Equity and Fiscal Responsibility Act of 1982 to expand the availability of compassionate and supportive care to Medicare’s many beneficiaries suffering from terminal illness at the end of life. Eligibility for hospice is based upon a physician’s certification that the patient has a terminal illness with a life expectancy of six months or less if the illness runs its normal course. When a patient elects hospice under Medicare, he or she agrees to forgo other “curative” treatment for the terminal illness. While the cost of most hospice care is covered by Medicare, the patient may be responsible for copayments related to drugs for symptom control or management and facility-based respite care. The patient is also responsible for copayments related to any regular Medicare services unrelated to the terminal diagnosis.

In recent discussion, some members of the Medicare Payment Advisory Commission (MedPAC) have suggested that it may be advisable to consider imposition of some type of copayment for Medicare hospice services.

RECOMMENDATION: Congress should reject imposition of additional copayments on beneficiaries for Medicare hospice services and other changes that would discourage use of the hospice benefit.

RATIONALE: Historically copayments have been imposed on health care services to reduce overutilization of services. While use of hospice services has grown significantly through the years, many Medicare beneficiaries are referred to hospice too late to reap its full benefit, and many more lack sufficient knowledge or understanding of hospice to consider it a viable option at the end of their lives. This is particularly the case for minority and low-income Medicare populations – who are the least likely to be able to afford additional cost-sharing burdens.

Beneficiaries who elect Medicare hospice services must agree to forego curative care for their terminal illness. Given that many “curative” interventions for terminal illnesses can involve administration of costly new medications and treatments, it is not surprising that numerous studies have documented that appropriate use of hospice services can actually reduce overall Medicare outlays while at the same time extending length and quality of life for enrolled beneficiaries.

While valid concerns have been raised about the length of time some Medicare beneficiaries are on hospice service, the median length of stay under the hospice benefit is about 17 days, and 95 percent of hospice care is provided in the home. In lieu of imposing additional beneficiary cost-sharing that could discourage appropriate and desirable use of the hospice benefit, Congress and other policymakers should explore additional ways to ensure that hospice services are being ordered for patients that are truly eligible, such as through physician education.

ENSURE ACCESS TO CARE FOR RURAL HOSPICE PATIENTS

ISSUE: Hospices are reimbursed one of four per diem rates based on the level of care provided. At least 95 percent of the care provided is in the patient's residence. Based on the demographics in rural areas, there are naturally fewer patients needing hospice services than is the case in urban areas. As a result, rural hospices must offer the full hospice benefit at a generally higher cost per patient. The benefit was originally enacted with a per-patient cap to be calculated on an aggregate basis with the thought that some patients would require fewer resources than others, thus making those excess cap payments available to offset the costs of more resource-intensive patients. This works if a hospice has a large enough case load to balance expenses. However, if a rural hospice has several high cost patients and a relatively small patient census, there are fewer lower cost patients to help balance expenses and keep the hospice below cap.

RECOMMENDATION: Congress should enact a five percent add-on for hospices located in and caring for patients in rural areas.

RATIONALE: Hospices in rural areas have difficulty recruiting and retaining adequate staff to meet the full panoply of services required under the Medicare hospice benefit. Additionally, hospice caregivers must drive greater distances to patients' residences than in urban areas. There is no consideration of consistently more expensive fuel costs in hospice reimbursement rates. The hospice wage index is updated annually using the most currently available hospital wage data as well as any changes by the Office of Management and Budget in the core-based statistical areas followed by the budget neutrality adjustment. In most states, the rural wage index is lower, resulting in comparatively lower reimbursement rates.

MONITOR PAYMENT REVISIONS TO MEDICARE HOSPICE BENEFIT

ISSUE: The Medicare hospice benefit (MHB) was created in 1982 to care for terminally ill cancer patients. The Medicare Payment Advisory Commission's (MedPAC) June 2008 Report to the Congress stated that, although the benefit was created to care for terminally ill cancer patients, they are now a minority of MHB participants. Currently, patients with diagnoses such as Alzheimer's disease, nonspecific debility and congestive heart failure make up the majority of Medicare's hospice patients. Although the average length of stay (LoS) has been increasing, the more important median LoS remains at about 17 days, according to the MedPAC. In 1983, 20 percent of patients received hospice services for seven days; this has increased to about 30 percent. The current reimbursement structure was created by estimating the original cost of delivering routine home care (96 percent of the care given) by analyzing data collected during the 1980-1982 Medicare Hospice Benefit Demonstration Project. Despite significant technological, pharmaceutical, and medical care delivery advances over the past 25 years, there has been no reimbursement adjustment to reflect the changes. The shorter LoS increases per diem costs for each patient.

In the intervening years, costs for pharmaceuticals and pharmacotherapy for symptom control and pain management have increased dramatically. The advancement in technology has resulted in increased outpatient services such as palliative radiation therapy and chemotherapy with accompanying diagnostic procedures required to monitor responses and side effects resulting in increased outpatient services costs.

MedPAC issued recommendations to the Congress for revising the hospice reimbursement system in its March 2009 Report to the Congress. It reiterated those recommendations in its 2010 Report to Congress. Those recommendations include expansion of data collection and the creation of a new payment model that reflects the variation in the costs of care over the patient's length of hospice care.

The Centers for Medicare & Medicaid Services (CMS) began collecting numbers of visits and costs per visit for some of the services that hospices provide in July 2008. Data collection was expanded in January 2010. Collection and in-depth analysis of these and other data are essential to establishing an appropriate method for reforming payments for Medicare hospice services.

The final 2010 health care reform legislation (Public Law 111-148) requires the development of payment system reforms along the lines of the MedPAC recommendations (Section 3132(a)). Payment system reforms are authorized by P.L. 111-148 to be put in place no earlier than October 1, 2013.

Public Law 111-148, the final health reform bill, also includes some interim payment changes, including the institution of a productivity adjustment to the annual market basket inflation update beginning in FY2013. In addition, the final reform bill reduces the market basket index by 0.3 points in FY2013 through 2019, but makes provision to eliminate the market basket cut in each of FY2014 – 2019 if growth in the health insurance-covered population does not exceed 5 percent in the previous year.

RECOMMENDATION: Congress must carefully review MedPAC's recommendations and ensure the impact of making changes to the reimbursement system do not affect the ability of terminally ill Medicare beneficiaries to access the MHB when they reach the final stage of life. Congress should work with the National Association for Home Care & Hospice and the hospice industry in legislating any changes in the Medicare hospice benefit.

In the meantime, Congress should oppose any reductions in the annual updates until all payment reforms are instituted and then only after all issues related to coverage and payment for hospice services are fully examined. Any system reforms must assure preservation of access to care, quality of care, and reasonably sufficient reimbursement rates to maintain a viable and stable delivery system.

RATIONALE: Congress asked MedPAC to provide a report on the adequacy of the MHB reimbursement rates by June of 2002. They were unable to do so due to a lack of data. In 2004, MedPAC reported that Medicare would need to collect additional data in order to do a comprehensive evaluation of patient costs and services. In 2006, MedPAC again reported that the “necessary data are not available for research on potential payment system refinements.” In its June 2008 Report to the Congress, MedPAC stated, “Because of the lack of data on services provided to patients with specific diagnoses, we could not determine the adequacy of Medicare payments relative to the cost of hospice care on a condition-specific basis, nor could we determine conclusively whether the payment system encourages or discourages the admission of certain patients to hospice on the basis of profitability.” Despite recent efforts by CMS to collect data necessary to exploring options for hospice payment reform, it will take several years before CMS can begin a thorough analysis to determine if the current payment system is adequate or if there is a more appropriate payment structure. Congress must ensure this most humane service for America’s terminally ill patients and their families remains a benefit available at the hour of greatest need – the final stage of life.

OPPOSE DECREASING HOSPICE REIMBURSEMENT FOR DUALY-ELIGIBLE PATIENTS RESIDING IN NURSING FACILITIES

ISSUE: Since 1989, terminally ill Medicare patients residing in nursing homes could elect the Medicare hospice benefit (P.L. 101-239). When a patient is entitled to both Medicare and Medicaid, the state Medicaid program must pay the hospice at least 95 percent of the nursing home rate for room and board services as set forth by each state's Medicaid program. The hospice then reimburses the nursing home.

The contractual relationship between hospice programs and nursing homes has been under the scrutiny of the Department of Health and Human Services Office of Inspector General (OIG). In its report, *Hospice Patients in Nursing Homes*, OIG made recommendations to eliminate or reduce the Medicare or Medicaid payments for hospice patients living in nursing homes. If this action is taken without further data gathering and analysis of the nature and cost of hospice care provided in the nursing home, it could result in the complete lack of, or diminished access to, appropriate hospice services for these individuals.

The final 2010 health care reform legislation, Public Law 111-148, requires the development of payment reforms consistent with recommendations of the Medicare Payment Advisory Commission (H.R. 3560, Section 3132(a)). The new payment structure has not been predetermined; rather it is dependent on data development and analysis that has not yet been completed.

RECOMMENDATION: Congress should oppose any legislation that would decrease the reimbursement for hospice services for dually eligible patients residing in nursing facilities without appropriate data collection and analysis supporting such a change.

RATIONALE: Legislative changes to the hospice reimbursement and nursing home room and board reimbursement prior to an in-depth study and analysis of the services provided and the cost of those services could, in effect, deny access to a humane and compassionate approach to care for bona fide eligible terminally ill residents of nursing homes. Only after appropriate data collection and analysis is performed should any adjustments to Medicare or Medicaid payments be made.

A study, funded by the Agency of Healthcare Research and Quality, US Department of Health and Human Services and conducted by investigators from Brown University Medical School examined data from 183,742 nursing home residents in five states which showed strong evidence that nursing-home residents in hospice care have about half the chance of being admitted to a hospital in their last 30 days of life compared to peers not receiving hospice services. In March 2000, the Office of Disability, Aging and Long-Term Care Policy, Department of Health and Human Services, and the Urban Institute released a study, "Outcomes and Utilization for Hospice and Non-Hospice Nursing Facility Decedents."

The study showed that:

- Hospice patients in daily pain are twice as likely to receive level 3 analgesics as are non-hospice patients in daily pain.
- Hospice patients are less likely to be restrained, to receive tube or parenteral/IV feedings and to be given medications via intramuscular or intravenous routes.
- Hospice patients receive less occupational, speech and physical therapy.
- Hospice patients consistently have fewer hospitalizations, with the greatest differences observed 30 days prior to death (9.8 percent vs. 31.7 percent).

- A nursing facility's hospice concentration appears to have a strong influence on the hospitalization patterns of non-hospice patients. Non-hospice patients in a nursing facility with no hospice involvement had a 30 percent probability of dying in a hospital. Where there was a .01 to 5 percent hospice concentration, non-hospice patients had a 24 percent probability of dying in a hospital. Patients of nursing facilities with a 5+ percent hospice concentration had a 21 percent probability of dying in a hospital.

REINSTATE THE BUDGET NEUTRALITY ADJUSTMENT FACTOR IN THE MEDICARE HOSPICE WAGE INDEX

ISSUE: President Bush's proposed 2009 budget included a regulatory proposal that would permanently eliminate the budget neutrality adjustment factor for the hospice wage index resulting in about a 4 percent cut in the hospice reimbursement rates each year. The anticipated savings would be \$2.29 billion over five years. The Centers for Medicare & Medicaid Services (CMS) issued a Notice of Proposed Rulemaking (NPRM) calling for comments followed by issuance of a final rule. CMS essentially ignored the comments and began a three-year phase out of the BNAF, effective November 1, 2008. As a result of passage of the American Recovery and Reinvestment Act of 2009 which postponed elimination of the BNAF until October 1, 2009, CMS reinstated the BNAF back to October 1, 2008. In subsequent 2009 rulemaking, CMS modified the schedule for eliminating the BNAF to phase it out over a seven year period beginning in FY2010. That phase out started with a 10 percent reduction in FY2010 followed by six years of consecutive 15 percent reductions.

The House proposal for health care reform included a one year delay (until October 1, 2010) in the start of elimination of the BNAF (H.R.3962, Section 1113). This was not included in the final health reform legislation.

RECOMMENDATION: Congress should direct CMS to permanently reinstate the budget neutrality adjustment factor in the Medicare hospice benefit wage index annual update. CMS should be directed to collect sufficient data to responsibly analyze the need for refinements in the hospice reimbursement system before Congress acts to make permanent changes.

RATIONALE: The elimination of the BNAF creates a serious risk of loss of access to hospice care. The Medicare Payment Advisory Commission (MedPAC) has estimated that the average hospice margin for 2011 will be approximately 4.2 percent; full elimination of the BNAF will decrease hospice reimbursement by 4 percent. There is no reliable data available to indicate whether the majority of hospices would be able to sustain such an overwhelming cut in reimbursement rates. There is a very real danger of putting community hospices out of business resulting in a lack of access to the hospice benefit, particularly in rural areas. In January of 2009, MedPAC's Commissioners voted out a set of recommendations to the Congress that included changing the hospice payment system. These recommendations were repeated as part of MedPAC's 2010 recommendations to Congress. However, MedPAC is relying on CMS to gather the data needed to ensure responsible analysis prior to making any refinements/changes. CMS is in the process of collecting data on hospice services and costs.

In 1994, as a result of disparity in wages from one geographical location to another, CMS established a committee to negotiate a wage index methodology that could be accepted by the industry and the government. The National Association for Home Care & Hospice participated in the Hospice Wage Index Negotiated Rulemaking Committee along with representatives of CMS and other hospice stakeholders. On April 13, 1995, the Hospice Wage Index Negotiated Rulemaking Committee signed an agreement for the methodology to be used for updating the hospice wage index which is now in place. At that time, CMS agreed to continue the same budget neutrality adjustment factor that was put into place when the benefit was created in 1983. Given that the agreement was entered into in good faith by all parties, action in this area should only be considered as part of a broader effort to refashion the hospice benefit.

A June 2004 report by the Government Accountability Office (GAO) determined that 34 percent of hospices in 2000 and 32 percent in 2001 had higher costs than reimbursement. The GAO recommended that CMS collect comprehensive, patient-specific data on the utilization and cost of hospice visits and services to determine whether the hospice payment categories and methodology require modification. The Medicare budget also will suffer through the loss of hospice care. A recent Duke University study showed

that patients who died under the care of hospice cost the Medicare program an average of about \$2,300 less compared with those that did not.

PROVIDE FULL DISCLOSURE AND ENSURE SNF/NF MEDICARE BENEFICIARY RESIDENTS' RIGHT TO CHOOSE A HOSPICE PROVIDER

ISSUE: In 1989, Public Law 101-239 mandated the ability of terminally ill Medicare beneficiaries residing in skilled nursing facilities/nursing facilities (SNF/NFs) to access services under the Medicare hospice benefit (MHB). As SNF/NF residents become aware of the MHB, more of them are seeking hospice services. However, the SNF/NF is not required to offer hospice services, nor is it required to disclose at admission if residents will be able to access hospice services without the need to transfer to another facility. Further, if the facility does have an arrangement to provide hospice, it is not required to disclose the hospice program with which it has a contract to provide services to residents. Finally, a resident does not have the right to choose the hospice program that he/she will receive hospice services from in the facility.

RECOMMENDATION: Congress should require that SNF/NFs disclose upon admission whether or not hospice services are available at the facility, and the name(s) of the hospice(s) with which the facility has contracted to provide hospice services on site. Additionally, Congress should mandate that eligible Medicare beneficiaries residing in SNF/NFs have the right to receive hospice services from the Medicare-certified hospice of their choice.

RATIONALE: SNF/NFs should provide full disclosure regarding the availability of hospice services through the facility at admission so that potential residents are fully aware of whether or not they will be able to access hospice services at some time during their stay if needed. Such disclosure could help to avoid the significant upheaval and trauma that could result from a resident's transfer to a different facility in order to exercise his/her right to the hospice benefit. Potential residents should also be notified regarding the names of the program(s) through which hospice services would be provided if they elect the hospice benefit while in residence at the facility. Finally, Medicare beneficiaries eligible for the hospice benefit should have the right to choose which hospice will serve them. Currently, a terminally ill SNF/NF resident may only access the Medicare hospice benefit if the SNF/NF has a formal arrangement with a hospice program to provide services in the facility.

ENSURE ACCESS TO MEDICATIONS NECESSARY FOR PAIN CONTROL

ISSUE: Inadequate pain management has been identified by experts in the field as a national health concern. Recently proposed legislation regarding controlled substances that may be used legitimately for treating pain could inadvertently compromise the quality of palliative care because it empowers drug enforcement officials to prosecute physicians to determine their intent for prescribing medication. This could have the unintended consequence of discouraging or limiting physicians from adequately treating terminally ill patients. This type of legislation would create a negative impact on the basic needs and rights of terminally ill patients as well as their comfort, dignity and freedom from pain.

RECOMMENDATION: Congress should oppose any legislation that would directly or indirectly set limits or prohibit physicians from prescribing adequate and appropriate controlled substances for the management of pain related to terminal illness.

RATIONALE: Terminally ill patients should not suffer due to inadequate pain management and lack of access to appropriate medications. Creating laws and policies that impose arbitrary limitations on physicians who prescribe controlled substances could have the unintended consequences of discouraging or limiting adequate treatment of terminally ill patients.

ALLOW NPs TO CERTIFY PATIENTS FOR MEDICARE HOSPICE SERVICES

ISSUE: While a nurse practitioner (NP) is allowed to serve as a hospice patient's attending physician, since inception of the hospice benefit the Medicare program has permitted only physicians (medical doctors or doctors of osteopathy) to certify a patient as terminally ill and eligible for hospice services. The 2010 health reform legislation (The Patient Protection and Affordable Care Act -- Public Law 111-148) allows either a hospice physician or hospice nurse practitioner to gather clinical findings that support continuing eligibility for Medicare hospice care to satisfy the face-to-face encounter requirement for hospice patients expected to enter a third or later benefit period.

NPs are currently permitted under Medicare to order skilled nursing facility care if working in collaboration with a physician.

RECOMMENDATION: Congress should authorize NPs to certify eligibility for the Medicare hospice benefit.

RATIONALE: Given current concerns about the growing shortage of primary care health professionals and growing outlays in federal health care programs, full advantage should be taken of the significant clinical skills and capabilities that NPs could bring to the palliative and hospice care settings. The Institute of Medicine (IoM) of the National Academy of Sciences reported in October 2010 (The Future of Nursing: Leading Change, Advancing Health) that care provided by NPs and primary care physicians are similar in terms of their complexity, and advanced practice nurses are trained to provide many of the same services offered by physicians. In many areas NPs are helping to fill a growing gap. However, IoM noted that a number of regulatory and institutional obstacles still exist that prevent the health system from reaping "the full benefit of nurses' training, skills, and knowledge in patient care." Among these are prohibitions under the Medicare program that prevent NPs from practicing to the full extent of their training and experience, including prohibitions against NPs certifying beneficiaries eligible for hospice care. These limitations should be recognized and corrected.

MANDATE HOSPICE COVERAGE UNDER MEDICAID

ISSUE: In 1986, when Congress enacted legislation making the Medicare hospice benefit permanent, hospice care was made an optional benefit under Medicaid. Hospice care allows terminally ill patients to move out of acute care facilities into less expensive care arrangements, primarily their own homes. There, the hospice team of health care professionals and other specialists provide physical, emotional and spiritual care to make the remainder of a patient's life as comfortable and meaningful as possible. As of 2011, 48 states had chosen to offer the hospice benefit to Medicaid beneficiaries. However, as states experience growing budget concerns, many are taking steps to eliminate coverage of hospice under their Medicaid programs or limit the number of days covered, which would leave some of the country's most vulnerable of individuals without appropriate care at the end of life. South Carolina is one of the states that has, unfortunately, already announced its intent to eliminate the hospice benefit from its Medicaid program.

The 2010 health care reform measure greatly expanded the populations eligible for Medicaid. Additionally, as the result of a provision in the final health reform legislation, which became Public Law 111-148, states must now cover hospice and curative services concurrently for those children eligible for Medicaid or Medicaid-expansion Children's Health Insurance Program (CHIP) programs. However, hospice remains an optional benefit for adults.

RECOMMENDATION: Congress should mandate Medicaid hospice coverage for all populations served.

RATIONALE: States expanded their Medicaid programs to cover hospice care in an effort to provide a more cost-effective and compassionate manner of caring for terminally-ill adults and children, including indigent and disabled individuals. Mandating hospice under Medicaid would speed access to hospice services. Hospice, with its combination of inpatient and outpatient care and case management by an interdisciplinary team composed of doctors, nurses, social workers and counselors, can provide high quality, comprehensive end-of-life care for the terminally ill patient while saving taxpayer funds. But with the current financial strains on Medicaid programs, even some states that currently offer hospice are considering dropping their Medicaid hospice benefit.

PROTECT HOSPICE AGENCIES FROM THE IMPACT OF SEQUENTIAL BILLING

ISSUE: The Centers for Medicare & Medicaid Services (CMS) has imposed the longstanding hospital sequential billing policy on hospice agency claims. The policy prohibits providers from submitting claims for care to beneficiaries where previously submitted claims are pending. Claims processing can be delayed for weeks or months for many reasons, including medical review activities, common working file problems, CMS or fiscal intermediary (FI) claims processing problems, and pending claims from other providers. Hospices have continued to serve patients even though Medicare payments have been delayed for months.

RECOMMENDATION: Congress should require CMS to process and pay all clean claims as submitted regardless of whether previous claims have been processed, and pay interest on claims that are not processed in a timely fashion.

RATIONALE: Many hospices are small businesses with little financial reserve, dependent on uninterrupted payment for services delivered. Interruption of payment for weeks or months, while requiring agencies to continue services to hospice patients, can result in severe financial hardships.

OPPOSE IMPOSITION OF PENALTIES FOR ERRONEOUS CERTIFICATION OF TERMINAL ILLNESS

ISSUE: Medicare regulation (42CFR §418.22) requires that, in order to be eligible to elect hospice services, an individual's physician and the hospice medical director must certify, in writing, that the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. About 30 percent of persons use hospice for one week or less, up to 12 percent of patients receiving Medicare hospice survive longer than six months and the median length of stay is 16 days or less, according to a study "What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program?" from the Duke University Center for Palliative Care and Department of Medicine. It is often difficult to make the determination that a patient is terminally ill because the course of terminal illness is different for each patient. A recently-published study reported that the recommended clinical prediction criteria are not effective in a population with a survival prognosis of six months or less. This information demonstrates what has been well known by those in the hospice community: that prognostication is an inexact science. In a letter to all Medicare-certified hospices in the country, the then-Centers for Medicare & Medicaid Services Administrator reiterated that "In no way are hospice beneficiaries restricted to six months of coverage."

In the 2009-2010 health care reform measures no new penalties were proposed for erroneous certification of a terminal illness by a physician. Instead, the final legislation required that a hospice certifying physician (or nurse practitioner) determine continued eligibility prior to the 180th day and for each certification thereafter through a face-to-face encounter and attest to the visit. The face-to-face encounter is not reimbursed by Medicare.

RECOMMENDATION: Congress should oppose imposition of civil monetary penalties upon physicians for erroneous certification of eligibility for hospice care. Congress should also ensure proper reimbursement is provided for visits to confirm continuing eligibility for hospice care.

RATIONALE: Physicians should not be punished for possible underestimation of a terminally ill patient's life expectancy. The only ones to be punished by such a penalty will be those patients in need of hospice services whose physicians will avoid recommending this compassionate, humane, and patient-family-centered care due to fear of penalties for erroneously underestimating their prognosis.

SUPPORT DEMONSTRATIONS ALLOWING CONCURRENT CARE INCLUDING HOSPICE AND TRADITIONAL MEDICARE-COVERED SERVICES

ISSUE: People in the last phase of life need a different care system for many months or sometimes years before death. Eligibility for the Medicare hospice benefit is limited to people who have a terminal illness with a prognosis of six months or less. Most people die slowly of relentless but rather unpredictable chronic illness and disease. Studies show that about 75 percent of Americans die in institutions where they often receive futile high-tech interventions and are in pain. Currently, for a beneficiary in the last year of life Medicare spending is almost six times more than for those who are not in their final year of life. The last month expands to 20 times as high as average monthly expenditures for those not in their last year of life due to rapid acceleration of inpatient hospital spending. About 28 percent of Medicare funds are now spent on care in the last year of life, which is comprised, for the most part, of expensive, high-technological interventions and “rescue care.”

According to a recent study from the Duke University Center for Palliative Care and Department of Medicine, “What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program?” hospice saves the Medicare program an average of \$2309 per hospice user. It further states that one-fourth of persons use hospice for one week or less, up to 12 percent of patients receiving Medicare hospice survive longer than six months and the mean length of stay is 16 days or less.

Children in the last phase of life need a different care system for many months or sometimes years before death, as well. With children having potentially life-threatening conditions, it is particularly hard to predict how many months or years a child has remaining. Often parents are reluctant to stop aggressive treatment until the very end.

Demonstration projects are needed to study special care needs and financial reimbursement for comprehensive services for end-of-life care for children and for Medicare beneficiaries who are seriously ill or who suffer from a medical condition that is likely to be fatal.

The health care reform bill (H.R.3590; P.L. 111-148) includes a three-year demonstration program that allows Medicare hospice patients to receive concurrently all other Medicare-covered services needed by the patient. (Section 3121(b)) The program is expected to be budget neutral by establishing that concurrent care is cost effective. This provision is complemented with a comparable Medicaid change on hospice for pediatric patients (Section 2302).

These health care reform proposals also include authorization to award grants for the development of projects to educate health care professionals in pain care (Senate bill Section 4305) and an Institute of Medicine (IoM) conference on pain research (House bill Sections 2561-3).

RECOMMENDATION: Congress should fund the “concurrent care” demonstration; it should also enact legislation that would provide for demonstration projects to study special services and financing of end-of-life care in home care and hospice settings. These demonstrations should examine the needs of children as well as adults. The demonstration programs should support the delivery of concurrent non-hospice care.

RATIONALE: Demonstration projects that study special care needs and evaluate the practices and procedures that will improve patient outcomes and resource utilization for end-of-life care would contribute valuable information about care needs and costs at the end of life.

SUPPORT QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT PROGRAM FOR HOSPICE

ISSUE: The June 2008 hospice conditions of participation (CoP) require hospices to develop, implement, maintain, and evaluate an effective, data-driven quality assessment and performance improvement program. The Centers for Medicare & Medicaid Services (CMS) has directed hospices to either develop their own or use currently available systems of measures to track patient outcomes in such areas as pain management, quality of life, skin integrity, and patient satisfaction. The requirement will include retaining the information in a database that permits analysis over time. A CMS contractor completed one research and demonstration project to develop systems of measures for the hospice industry; CMS is looking to test the measures in a subsequent project. The National Association for Home Care & Hospice completed a quality assessment performance improvement (QAPI) collaborative project in 2007 that resulted in adapting and developing succinct data collection instruments to help hospices meet the need for data collection and contribute to the options CMS has to choose from.

The final 2010 health care reform legislation provides a strong start towards the development and implementation of a quality reporting program by mandating that the Department of Health and Human Services (HHS) publish hospice quality measures covering all dimensions of hospice quality and care efficiency by October 1, 2012, and that hospices begin reporting these measures in FY2014. Failure to submit quality measures by a hospice would result in a 2 point reduction in the annual market basket index update (Section 3004).

RECOMMENDATION: Congress should monitor efforts by CMS to develop quality measures and ensure the agency works with the hospice industry to establish standards of care for providers of the Medicare hospice benefit. Congress should also ensure that sufficient funds are available to CMS to support these efforts. In the interim, hospice organizations should be responsible for ongoing QAPI programs based on patient outcomes.

The following conditions must be met in implementing any outcome measurement system:

- Reliable and valid indicators.
- Number of outcome measures limited to those that most accurately predict quality.
- Method for risk adjustment.
- Standard assessment limited to items needed for outcomes measurement and risk adjustment.
- A simple system with clinical utility.
- A mechanism enabling CMS to validate agency data.
- Ongoing evaluation of the entire system.

RATIONALE: The ideal hospice quality assessment program would be based on what happens to patients; however, there currently are no standard outcome measures for hospice care. Research and demonstration projects are not factored into the current per diem reimbursement structure. Every effort must be made to keep data collection and the paperwork burden to a minimum to allow concentration of resources on patient care.

ENSURE THE PORTABILITY OF ADVANCE DIRECTIVES; SUPPORT ADVANCE CARE PLANNING CONSULTATIONS

ISSUE: Between 20 and 25 percent of Americans above the age of 18 have advance directives but are not assured that this legal document will be honored in any state other than the state in which it was executed. The law honoring advance directives from another state is unclear. An individual is burdened with the responsibility of having the advance directive meet the laws of any state in which he may be spending some time. There should be a nationwide policy on advance directives for individuals receiving items and services under titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq., 1396 et seq.), assuring that an advance directive validly executed outside of the state in which such advance directive is presented by an adult to a provider of services be given the same effect by that provider as an advance directive executed under the law of the state in which it is presented. This would assure that an individual's decisions directing end-of-life care will be followed.

The final health care reform legislation (Public Law 111-148) did not address the need for portability of advance directives. However, the original legislation approved by the House (H.R.3962) provided for payment to physicians and other health care professionals to provide a voluntary advance care planning consultation (Section 1233); it also contained a provision regarding the dissemination of advance care planning information (Section 240).

RECOMMENDATION: Congress should support legislation that ensures the portability of an individual's advance directive between health care facilities as well as between states. Congress should authorize voluntary advance care planning consultations under Medicare to educate beneficiaries on issues related to end-of-life care and end-of-life care planning.

RATIONALE: An advance directive belongs to the individual and should not be interfered with or interrupted by the laws of any particular state or health care facility. As an individual travels or relocates to a different state, his stated end-of-life-care choices should be honored based on the choices of the individual, not based on the location of the individual. Establishing a nationwide policy on advance directives that assures the portability of an individual's end-of-life care choices strengthens patient self-determination efforts and could encourage more individuals to communicate with families, physicians and health care providers about their end-of-life-care choices.

Voluntary advance care planning consultations under Medicare would help to familiarize beneficiaries with end-of-life care choices and the availability of the Medicare hospice benefit and the services available under it so that a beneficiary is more aware of the options available to them if terminal illness should occur.

ENACT HOSPICE-SPECIFIC COMPLIANCE MEASURES

ISSUE: Hospice, like most other health care segments, is not immune to the presence of participants that engage in improper, unethical and possibly illegal schemes for the sake of profit. At the same time, health care providers that operate well within the law are unable to effectively compete in the market when faced with competitors that offer kickbacks for patient referrals, bill for services not provided, or charge costs that are not part of delivery of services.

The final health reform law (Public Law 111-148) allows the Department of Health and Human Services (HHS) to require compliance plans and background screening of owners and managers, as well as authorizes the Secretary of HHS to impose a moratorium on new providers (Section 6401). The law also extends the criminal background check pilot program at CMS (Section 6201).

RECOMMENDATION: Congress should continue its work to ensure compliance with federal requirements and to combat waste, fraud, and abuse in our nation's health care system by passing a hospice-specific compliance package that includes:

- The institution of corporate compliance plans by all Medicare-participating hospices to ensure adherence to all federal and state laws;
- Mandatory screening and federally-funded background checks on all individuals wishing to open a Medicare hospice;
- Strengthened program participation standards that include experience credentialing and competency testing of hospice personnel responsible for maintaining compliance with Medicare standards;
- Investment of sufficient government and industry resources to expedite refinements in the structure and payment methodology of the hospice benefit under Medicare;
- Providing consumers and prospective consumers of Medicare hospice services with a clear summary of program coverage requirements to enhance consumer reporting of non-compliant activity;
- Implementation and development of credentialing and competency standards for government contractors and federal regulators responsible for issuing Medicare determinations; and
- Enhancement of education and training of hospice staff through joint efforts with regulators and government contractors.

RATIONALE: A comprehensive compliance package that is specifically focused on hospice is good "preventive medicine" to help maintain compliance and ensure proper expenditures of limited health care dollars for appropriate hospice care. It is in the best interests of compliant hospice organizations to take steps to keep unscrupulous providers from operating within federal and state programs. The health care reform proposals go a long way toward meeting the compliance measures needed to succeed.

MANDATE FREQUENCY OF SURVEYS FOR MEDICARE HOSPICE BENEFIT PROVIDERS

ISSUE: About 16.5 percent of Medicare hospice benefit providers are surveyed each year. There is no legislative requirement for the frequency of surveys for providers of the Medicare hospice benefit (MHB). The Centers for Medicare & Medicaid Services' (CMS) failure to require that hospice providers be surveyed on a regular basis can result in lack of compliance with regulations and poor quality of care. CMS states they recognize the problem but do not have the funds necessary to conduct more frequent surveys. CMS currently has hospice providers on a six-year cycle for surveys but that sometimes extends to 10 years and more in some parts of the country.

RECOMMENDATION: Congress should mandate that CMS ensure that MHB providers are surveyed at least every three years and provide the funding to do so.

RATIONALE: When the MHB was created by the Congress, in order to assure quality of care and implement the benefit, CMS was given the responsibility of creating regulations to be followed by providers of hospice services. As the next step of this responsibility, there need to be regular surveys to ensure compliance with these regulations. Recipients of the MHB should be afforded the same protections provided to recipients of other Medicare benefits.

ELIMINATE MEDICARE PROVISION REQUIRING HOSPICE SOCIAL WORKERS TO PRACTICE UNDER THE DIRECTION OF A PHYSICIAN

ISSUE: Under § 1861 (dd) (1) (c) of the Social Security Act, social workers are the only members of the hospice interdisciplinary group required to be under the direction of a physician. Social workers, as members of the interdisciplinary team, work in concert with the members of the team, which is guided by the team coordinator or clinical director. The interdisciplinary team, as defined by the hospice statute, consists of at least a doctor of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or other counselor. The statute also defines the role of the registered nurse as the coordinator of the plan of care for the patient and family.

RECOMMENDATION: Congress should amend Section 1861 (dd) (1) (c) of the Social Security Act to eliminate the requirement that a hospice social worker function under the direction of a physician and require instead that the interdisciplinary team be under the direction of the team coordinator or clinical director and that each discipline should be under the direction of the supervisor of that discipline.

RATIONALE: Placing social workers under the direction of a physician imposes an unnecessary burden on the team and agency and creates needless complexity by requiring convoluted reporting patterns and organizational charts. It also undermines the concept of the team by mandating that one team member report to another team member rather than to the team leader. Social workers should report to their discipline's supervisor or the team leader, not a physician. Further, all members of the team should be under the direction of the clinical director who is responsible for the delivery of quality services in an appropriate and timely fashion.

ENSURE HOME CARE AND HOSPICE PARTICIPATION IN TRANSITIONS IN CARE AND OTHER HEALTH CARE DELIVERY REFORMS

ISSUE: The Patient Protection and Affordable Care Act of 2010 (PPACA) includes significant health care delivery system reforms in addition to expansion of Medicaid eligibility, health insurance reforms, and Medicare payment changes. These health care delivery reforms have the potential to radically alter how and where patients receive care. Overall, these reforms shift the focus of care from inpatient services and institutional care to the community setting. Further, these reforms provide a combination of incentives to clinically maintain patients in their own homes and penalties for excessive re-hospitalizations of patients. Importantly, these reforms also focus on individuals with chronic illnesses, providing support for health care that prevents acute exacerbations of their conditions and avoids both initial and repeat hospitalizations.

PPACA includes, among other health care reforms, new benefits, payment changes, pilot programs and demonstration projects such as Accountable Care Organizations, Transitions in Care, penalties for re-hospitalizations, a Community Care Management benefit, and trials of integrated and bundled payment for post-acute care.

Home care and hospice services offer an opportunity for these new programs to work at their highest potential for efficiency and effectiveness of care. Home care and hospice bring decades of experience in managing chronically ill individuals with a community-based care approach, limiting the need for inpatient care and creating a comprehensive alternative to most institutional care.

If these health care delivery reforms are to fully succeed, the Centers for Medicare and Medicaid Services (CMS) must recognize the value of home care and hospice as part of the solution to out-of-control health care spending, particularly for patients with chronic illnesses. CMS should take all possible steps to ensure that any pilot programs or demonstration projects include home care and hospice as active participants and, where appropriate, as the qualified, controlling entity to manage post-acute care and patients with chronic illnesses.

RECOMMENDATIONS: Congressional reforms of the health care delivery system recognize home care and hospice as key partners in securing high quality care in an efficient and efficacious manner. Congress should monitor closely CMS's implementation of the health care delivery reform provisions in PPACA to ensure that the intended goals are fully met. Congress should encourage CMS to look to home care and hospice as part of the solution to rising health care spending in Medicare and Medicaid, including through community based chronic care management. Congress should investigate and remove any existing laws and regulations that create barriers to the inclusion of home care and hospice entities as integrated partners or participants with other health care organizations in transitions in care actions, bundling of payments, or other delivery of care innovations.

RATIONALE: Community-based care is a valuable, but under-utilized health care asset with respect to efforts to reduce hospitalizations and rehospitalizations. Further, community-based chronic care management has long been provided effectively by home health agencies and hospices. However, the antiquated structure of Medicare benefits has prevented its application at full capacity. The reforms in PPACA present the opportunity to build a new care delivery model that is not handicapped by this out-of-date structure and to overcome longstanding weaknesses in health care delivery.

ENSURE APPROPRIATE MEDICAID RATES FOR HOME CARE AND HOSPICE

ISSUE: Medicaid has taken on an increasing role in providing coverage of home care and hospice services to children, the disabled, and the elderly. In addition, the Patient Protection and Affordable Care Act of 2010 (PPACA) expands Medicaid funding for home care services by nearly \$13 billion through 2019. Data already indicates that Medicaid expenditures for home care and hospice services now exceed Medicare expenditures. A significant part of the reason behind the Medicaid growth is the flexibility allowed states in the structuring of Medicaid coverage and the recognition that home care is a viable, cost-effective alternative to institutional care. However, as Medicaid expenditures for home care and hospice have increased along with general strains on state Medicaid budgets, reimbursement rates have failed to keep pace with increasing costs of care and, in some cases, they have been subject to reduction for purely budgetary savings purposes.

Federal Medicaid law establishes a broad and somewhat ambiguous standard for rate setting that merely requires the states to set rates at a level sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. The “sufficient access” standard for rate setting operates in a manner that requires a demonstration that individuals in need of care cannot find it solely because of inadequate rates. This method fails to prevent the loss of services and only reacts when inaccessibility to services reaches a high enough level to gain political attention. It is understood that the Centers for Medicare and Medicaid Services may consider proposing a new federal regulation in 2011 that establishes rate setting standards. Further, with the initiation of the Medicaid Access and Payment Advisory Council (MACPAC) it is expected that Congress will be better advised on the shortcomings of existing Medicaid payment rates throughout the states.

Inadequate reimbursement for home care and hospice services has affected all populations served in the home and in all of the various home care programs available under Medicaid. Technology intensive home care services, personal care services, private duty nursing services, and basic home health services are often reimbursed at levels of payment equal to 60 to 75 percent of the cost of the provision of care. The result is a very fragile Medicaid home care benefit structure that relies on payment subsidization by non-Medicaid sources, thereby jeopardizing continued access to care.

RECOMMENDATION: Congress should enact legislation that requires that states continually assess Medicaid home care and hospice rates of payment and the methodology utilized for establishing rates. The legislation should further require that rates be reasonable and adequate so as to:

- Assure access to care comparable to the non-Medicaid patient population;
- Ensure reimbursement sufficient for providers to conform with quality and safety standards; and
- Guarantee payments sufficiently adequate to incentivize providers of care to operate efficiently while meeting the cost of care provision.

RATIONALE: Virtually all Medicaid home care reimbursement systems pay insufficient attention to the effect of payment rates on patients’ access to care or the cost of efficiently delivering services. Inadequate rates also severely impact the ability of the provider to meet quality and safety standards. Requiring states to engage in an annual analysis of the rate setting methodology and the adequacy of payment rates combined with federally mandated goals for a rate setting process will ensure that Medicaid recipients receive high quality care.

REQUIRE MEDICAL RESIDENTS AND INTERNS TO HAVE HOME CARE AND HOSPICE EXPERIENCE AS PART OF THEIR GRADUATE MEDICAL EDUCATION

ISSUE: Medicare pays for the education of medical residents and interns at virtually all hospitals in the United States. Much of the education is biased toward care provided in the hospital setting. However, a great deal of medical care is moving out of hospitals into the community. Several factors precipitated this shift. Advances in medical technology allow for treatments such as infusion therapy to be provided in the home setting. Existing financial incentives for hospitals to discharge patients quickly means that services such as rehabilitation are now being provided in the home rather than the acute care setting and special arrangements for intensive home therapy prior to hospitalization in the case of chemotherapy, for example, are increasingly commonplace.

In addition, the marked increase in lifespan has resulted in an increasingly elderly population with chronic illnesses which, while they limit functioning, are not life-threatening, and therefore are managed in non-acute settings, primarily the home. Medicare requires physicians to sign a plan of care for beneficiaries to receive home care services, but many physicians may have never practiced outside of a hospital. Often, doctors discharge patients to their home without considering the home environment, support system, and resources.

Physicians must learn to function effectively in “non-traditional” care sites, particularly the home setting. As few medical schools provide their students with comprehensive home care experiences, such education must take place at the residency level. A 1994 survey of US medical schools showed that only half of all medical schools afford the opportunity for home health and hospice education before graduation.

RECOMMENDATION: Congress should mandate that all residents and interns have home care and hospice experience included in their curriculum.

RATIONALE: Medicare pays for the direct costs of graduate medical education. The mandate that residents and interns spend time in the community does not add costs. Currently, Medicare will reimburse a hospital for residents’ time spent in education outside of the hospital as long as the resident spends his or her time in patient care activities.

In the community, residents will learn about the services available and will be better able to coordinate care between the hospital and the home setting. The importance of this increases as hospitals continue efforts to shorten lengths of stay. Indeed, it is now essential to prevent unnecessary hospitalization and long-term institutional care. Moreover, increased understanding of home health services will aid physicians in later determining appropriate levels of Medicare home health utilization for individual beneficiaries. At a minimum, education should include pain and symptom control and a requirement to make home visits.

PROVIDE SUFFICIENT HOME CARE AND HOSPICE PAYMENTS SO THAT AGENCIES CAN PROVIDE APPROPRIATE WAGES AND BENEFITS TO CLINICAL STAFF

ISSUE: The severe limitations on reimbursement under Medicare and Medicaid make it extremely difficult for agencies to comply with any requirements to increase wages, much less provide wages and benefits that reflect the worth of the care provided by nurses, paraprofessionals, and other caregiving staff. In fact, current economic restrictions have resulted in many agencies cutting staff or seeking ways to save on patient care costs by limiting workers' hours or reducing wages or benefits. Payment under Medicaid and under the prospective payment system for home health and payment rates for hospice care services must be adequate to allow for increased wages and benefits for nurses and home care aides.

RECOMMENDATION: Congress should provide that federal programs (Medicare/Medicaid) that finance home care and hospice services adjust reimbursement to allow for appropriate wage and benefit levels for all clinical staff. Additionally, Congress should consider implementing a wage pass through for home care and hospice workers under Medicare and Medicaid.

RATIONALE: The U.S. Census estimates that nearly 20 percent of home care paraprofessionals and their families live in poverty, and 30 to 35 percent of those who are single parents receive food stamp assistance. Studies indicate that low wages affect an agency's ability to recruit and retain direct care workers. Agencies throughout the nation have begun to experience severe hardships in recruiting and retaining clinical staff.

Increasingly, efforts are being made to document the relationship between wages and quality of care. Without sufficient reimbursement, financially strapped home care and hospice agencies are finding it extremely difficult to provide quality care, pay competitive wages, and foster job satisfaction.

ENSURE AVAILABILITY OF HOME CARE AND HOSPICE PERSONNEL, PARTICULARLY IN RURAL AND OTHER UNDERSERVED AREAS

ISSUE: There is an increasing need for home care and hospice services as a result of the aging of the population, clarification of Medicare coverage policies, continued earlier hospital discharges, and patient preferences for home care and hospice. While this trend has leveled off, home care and hospice providers continue to report shortages of nurses, home care aides, therapists and social workers, especially in rural areas. Periodic reductions or freezes in agencies' market basket inflation updates, in addition to other cuts, have made it increasingly difficult for agencies to offer competitive wages and benefits. Increased regulatory burdens on home visiting staff have also discouraged workers from continuing in home care.

Home health agencies generally require that newly-hired staff have one year of prior work experience because home caregiving requires that professionals take on substantial responsibility; agencies also have financial difficulty providing the level of supervision new nurses and therapists need in the home setting. Reductions in the workforce in inpatient settings have greatly reduced the opportunities for nursing and physical and occupational therapy graduates to obtain on-the-job experience.

Recruitment and retention of home care and hospice personnel, including nurses and home care aides, is especially difficult in rural and other underserved areas. Providing health care in these areas requires special knowledge, education, and commitment on behalf of health care providers. Continuing education and training often are not readily available. Health care services can be particularly interdependent in rural communities: when a rural hospital closes, many affiliated health care personnel and services leave the area as well.

In 2009, the Office of Occupational Statistics and Employment Projections at the Bureau of Labor Statistics, within the U.S. Department of Labor, released employment projections for the American workforce for 2008-2018. The health care and social assistance sector is projected to grow substantially during this 10 year period. In fact, 17 of the 30 fastest growing occupations are related to health care and medical research. The projected job growth in the health care sector includes increases in the following occupations: home health aides, an increase of 50 percent; personal and home care aides, an increase of 46 percent; physical therapists aides, an increase of 36.3 percent; physical therapist assistants, an increase of 33.3 percent; occupational therapists aides, an increase of 30.7 percent; physical therapists, an increase of 30.3 percent; and occupational therapists assistants, an increase of 29.8 percent.

It is critically important to both increase the supply of qualified health care staff to maintain patient care access and to assure that these staff have the skills needed to provide high quality treatment and rehabilitation services in the home setting. Federal and state regulations should promote the use of nurse practitioners, physician assistants, and other qualified home health personnel.

Congress took legislative action in the 107th Congress to help alleviate the nurse shortage. Specifically, the Nurse Reinvestment Act (H.R. 3487, P.L. 107-205) would establish a National Nurse Service Corps to provide scholarships and loans to nursing students who agree to serve in a public or private non-profit health facility, including home care agencies and hospices, determined to have a critical shortage of nurses. The legislation also establishes nurse retention and patient safety enhancement grants to assist health care facilities to retain nurses and improve patient care delivery by encouraging more collaboration between nurses and other health care professionals and more involvement by nurses in the decision-making process.

In addition, the bill establishes grants for comprehensive geriatric nurse training, establishes a faculty loan cancellation program, establishes a career ladder program that will assist individuals in the nursing

workforce to obtain more education, and establishes partnerships between health care providers like home care agencies and schools of nursing for advanced training. Lastly, the bill establishes a fund for public service announcements that will advertise and promote the nursing profession and educate the public about the rewards of nursing.

RECOMMENDATIONS: Congress should fund grant programs for educating therapists, medical social workers, nurses, home care aides, and other home care and hospice personnel with a focus on home- and community-based practice in areas where shortages exist. The number of schools providing therapy programs must be increased and the number of slots available in these schools should be expanded. Special incentives such as loan-forgiveness programs to fund schooling and education should be developed to recruit students for practice in geographic areas with staff shortages, such as rural and inner city areas. Grants to educational facilities should be made available for innovative approaches to recruitment and education of home health care personnel, including consideration of job “ladders” and “classrooms without walls,” and for faculty development. Congress should fund home care internship demonstration projects for nurses and physical and occupational therapists to provide a year of on-the-job education for new graduates. Finally, Congress should provide incentives to ensure that a sufficient number of qualified faculty members are available to train the nation’s future health care workforce.

Congress should request Government Accountability Office and Medicare Payment Advisory Commission (MedPAC) studies on the shortage of personnel in the home care and hospice settings, with special attention to rural and inner-city areas, and with recommendations on what can be done to overcome this problem.

RATIONALE: The demand for home care and hospice services will continue to increase as the elderly and disabled population grows. More qualified personnel are necessary to meet the increased needs. These personnel should have skills that enable them to apply their services to home- and community-based care situations. Further, these qualified home care and hospice personnel should be encouraged to practice in rural and underserved areas. When professionals are scarce, the cost of providing care increases. Putting funds into education and other incentive programs will ultimately lower costs to consumers.

REQUIRE FEDERALLY FUNDED CRIMINAL BACKGROUND CHECKS AND ESTABLISH A NATIONAL REGISTRY SYSTEM

ISSUE: At times, media attention has focused on the unacceptable, but few, cases of abuse of home care clients, fueling consumer anxiety and industry concern about the need for better consumer protections. Although any fraud and abuse is unacceptable, it's important to note that cases of consumer abuse in home care are rare, certainly the exception rather than the rule. The overwhelming majority of home care workers perform their duties with compassion and integrity; likewise, the vast majority of home care agencies provide reputable, legitimate, quality care. However, as in any industry, there are a few unscrupulous individuals who defraud and abuse the system and its patients.

In March 1997, the then-Health Care Financing Administration published proposed rules governing the conditions of participation (CoP) in the Medicare program which included a provision to require home health agencies to conduct a criminal background check of home health aides as a condition of employment. The Hospice CoP require hospices to conduct a criminal background check on all hospice employees and contracted workers providing direct patient care or with access to patient records.

Criminal background checks cannot be relied on as the sole method of keeping consumers safe. No matter how effective, the criminal background check should not substitute for the most basic and prudent personnel practices that any responsible employer would undertake to establish the appropriateness, safety and suitability of an applicant.

Under a provision in the fiscal year 1999 Omnibus Appropriations legislation, a home care agency or a nursing facility is permitted but not required to submit a request to the Attorney General (through the appropriate state agency) to conduct a criminal background check on applicants who would be involved in direct patient care. This provision, which does not mandate criminal background checks, is an important step toward making criminal history information more accessible. It is very likely that Congress will continue to consider mandatory criminal background check provisions as the capacity of federal systems to process such requests is improved.

In the 106th Congress, Senator Herb Kohl (D-WI) and Representative Pete Stark (D-CA) introduced "The Patient Abuse Prevention Act" (PAPA) to require criminal background checks for long term care workers. Senator Kohl renewed the effort by reintroducing the bill in the 107th and 108th Congresses, the latest version of which was S.958. Provisions of the bill were included as an amendment to S.1, the Senate version of the Medicare Prescription Drug, Improvement, and Modernization Act. The amendment was dropped in conference with the House and replaced by a pilot program before final passage of the legislation (Public Law 108-173).

Section 307 of P.L. 108-173 required the Secretary of HHS to establish pilot projects in no more than 10 states for the purpose of expanding background checks for workers with direct patient access who are employed by Medicare and Medicaid long term care providers. CMS selected seven states to participate in the Background Check Pilot Program: Alaska, Idaho, Illinois, Michigan, Nevada, New Mexico, and Wisconsin. Long term care facilities or providers include nursing homes, home health agencies, hospices, long term care hospitals, and other entities that provide long term care services (except for those paid through a self-directed care arrangement). Separate funds were earmarked to conduct an independent evaluation of the background check pilot which has now been completed.

Senator Kohl introduced legislation in the 110th and 111th Congress to expand the pilot projects to make the program available to every state. His legislation was included in the Patient Protection and Affordable Care Act (H.R. 3590; Public Law 111-148) in March 2010.

RECOMMENDATION: Congress should support efforts to establish a national registry and background check system administered by the states for all health and long term care workers, including independent providers, who provide direct care to patients. Such a system should be voluntary until an efficient and accessible background check system is in place. Federal and state background check requirements should not be duplicative. Any new requirement should not impose burdensome supervisory requirements on home care agencies while a background check is pending and must protect providers from liability during a provisional period of employment. Further, it should mandate that agencies be adequately reimbursed for the cost of the background checks. A standard definition of abuse, neglect, or misappropriation of patient property should be used for purposes of establishing a national registry.

RATIONALE: As the demand for high quality home care and hospice increases, it is critical that all services are delivered with care and compassion by ethical providers. Fraud and abuse cannot be tolerated in any form. The care environment must be safe for patients and caregivers and free of abuse, exploitation and inappropriate care. Criminal background checks and a national registry are important components of ensuring consumer safety.

In state laws the trend is toward background check requirements for nursing and home care aides only; however, there is currently no consistent systematic mechanism through which other direct care staff are checked. It is in the best interest of consumers of home care and other health services for all direct care staff to be screened.

RECOGNIZE TELEHOMECARE INTERACTIONS AS BONA FIDE MEDICARE AND MEDICAID SERVICES

ISSUE: Telehomecare is the use of technologies for the collection and exchange of clinical information from a home residence to a home health agency, a secure monitoring site or another health care provider via electronic means. The scope of telehomecare includes, but is not limited to, the remote electronic monitoring of a patient's health status and the capturing of clinical data using wireless technology and sensors to track and report the patient's daily routines and irregularities to a healthcare professional; electronic medication supervision that monitors compliance with medication therapy; and two-way interactive audio/video communications between the provider and patient allowing for face-to-face patient assessment and self-care education.

With increasing expectations for quality care delivery, the use of technology to deliver home health and hospice care is increasingly being recognized as an invaluable tool for an industry challenged by diminished reimbursement formulas. For example, through the use of telehomecare, the Veterans Administration realized a 25 percent reduction in the number of bed days of care, a 19 percent reduction in hospital admissions, and an 86 percent satisfaction rate of veterans being seen in their home with their Care Coordination/Home Telehealth (CCHT) program. Home care agencies have also been readily adopting remote monitoring technologies (In a 2009 NAHC-sponsored study ["The Blackberry Report: The National State of the Home Care Industry", conducted by Fazzi Associates], 23 percent of HHAs report using telehealth systems, up from 17.1 percent in 2006).

Despite significant progress that has been made in the development and use of advanced telehomecare technologies, the absence of a uniform federal Medicaid and Medicare telehomecare guideline that provides for comprehensive reimbursement mechanisms and a uniform certification process for certifying telehealth providers, is creating barriers to more widespread adoption of telehomecare and the establishment of services employing telehomecare. Currently, the Centers for Medicare & Medicaid Services (CMS) does not recognize telehomecare as a distinctly covered benefit under Medicaid, nor does it allow for telehomecare technology costs to be reimbursed by Medicare.

Small inroads have been made under Medicaid as at least 12 state Medicaid programs have passed Medicaid waivers that include the reimbursement of telehomecare. Unfortunately, CMS maintains that telehealth visits do not meet the Social Security Act definition of home health services "provided on a visiting basis in a place of residence" under the Medicare program. CMS regulations (42 CFR 484.48(c)) defines a home health "visit" as "an episode of personal contact with the beneficiary by staff of the HHA [home health agency]."

Over the past few years, Congress has taken integral steps to expand the access of technology into the delivery of home health care. Most notably, telehomecare champions Senator John Thune (R-SD) and Amy Klobuchar (D-MN) have taken up the cause and introduced the "Fostering Independence Through Technology (FIT) Act" to mandate that the Secretary of Health and Human Services (HHS) establish pilot projects under the Medicare program to provide monetary incentives for HHAs to utilize home monitoring and communications technologies. In 2009, a companion bill was introduced in the House of Representatives by Rep. Tim Walz (D-MN).

In 2008, and again in 2009, Representative Mike Thompson (D-CA) introduced "The Medicare Telehealth Enhancement Act" which provided a number of provisions that addressed the need for enhanced telehealth services including, for Medicare's purposes, reimbursement for home health telehomecare visits by home health agencies, coverage of remote patient management services including home health remote

monitoring, and establishment of a demonstration project to evaluate the impact and benefits of including remote patient management services for certain chronic health conditions.

Congressional allies from both the Senate and the House also sent a letter to CMS conveying their support for the Center for Medicare & Medicaid Innovation (CMMI) created by The Affordable Care Act and recommending the FITT remote monitoring model as one of the pilot projects the CMMI should adopt to effectively test in both rural and underserved urban areas by home health care providers.

RECOMMENDATION: Congress should clarify legislatively that telehomecare “constitutes a service(s) ... provided on a visiting basis in a place of residence used as an individual’s home” as defined in §1861m of the Social Security Act, and Medicare should provide appropriate reimbursement for technology costs to HHAs and hospices. CMMI should approve demonstration projects that would allow for new ways to use telehomecare technologies to monitor patients and avoid more costly health care interventions, such as the concepts embodied in the FITT Act. Congress should establish telehomecare services as a distinct benefit within the scope of federal Medicaid coverage. The benefit should include all present forms of telehealth services and allow for sufficient flexibility for states to include emerging technologies. Finally, Congress should ensure that all health care providers, including HHAs and hospices, have access to appropriate bandwidth so that they can take full advantage of advances in technology appropriate for care of homebound patients.

RATIONALE: Telehomecare is a proven and important component of health care today and vital to reducing acute care episodes and the need for hospitalizations for a growing chronic care population. Establishing a basic federal structure for Medicare and Medicaid reimbursement and coverage of telehomecare services will permit states to more easily add this important service to the scope of Medicaid coverage and benefit the entire Medicare program.

Studies indicate that over half of all activities performed by a home health nurse could be done remotely through telehomecare. Evidence from these studies has shown that the total cost of providing service electronically is less than half the cost of on-site nursing visits. Given the financial constraints on agencies under the prospective payment system (PPS), providers of care should be granted maximum flexibility to utilize cost-effective means for providing care, including non-traditional services such as telehomecare that have been proven to result in high-quality outcomes and patient satisfaction.

PROVIDE FINANCIAL ASSISTANCE TO HOME CARE AND HOSPICE PROVIDERS TO EXPAND USE OF INFORMATION TECHNOLOGIES AND IMPLEMENT ELECTRONIC HEALTH RECORDS

ISSUE: Administrative costs and paperwork represent significant expenses in health care. The home care industry has been especially paper intensive. Medicare billing, OASIS assessment, patient charting compliance with the Health Insurance Portability and Accountability Act (HIPAA), and many other activities greatly increase administrative costs. The implementation of the Medicare home health prospective payment system has required a wholesale revision in agencies' billing, documentation, data collection and data utilization.

While 80 percent of HHAs currently use an electronic fiscal, billing, and backroom system, changes in documentation responsibilities and advancements in technology will continue to challenge the ability of HHAs to maintain up-to-date systems. The purchase of multi-purpose, integrated clinical and financial systems with multiple electronic capabilities requires a significant capital investment. Traditionally, small business loans have not been readily available to most HHAs because agencies are not viewed as a good credit risk. Many are dependent on Medicare for most of their revenues. Keeping pace with these new technology needs has been beyond the financial capabilities of many HHAs.

HHAs are also readily adopting and using new electronic health records (EHRs) to respond to the Obama Administration's call on health care providers to adopt EHRs by the year 2014. As compared to physicians and hospital discharge planners, HHAs are incorporating EHRs in their practices. According to the latest figures, it's estimated that more than 65 percent of HHAs presently use electronic medical records. Therefore, while HHAs are responding to the need to implement EHRs, the great challenge to HHAs is to maintain interoperability with other health care providers.

RECOMMENDATION: As the HITECH Act is implemented, which Congress passed as part of the American Recovery and Reinvestment Act ("Stimulus bill"), Congress needs to continue to work with the Obama administration to provide financial support for HHAs to facilitate the implementation of electronic capabilities. The Office of the National Coordinator for Health Information Technology, working in cooperation with industry and provider input from the HIT Standards and Policy Committees, should incorporate assistance to all health care sectors so that financial support for the transition to interoperable EHRs continues beyond the assistance currently provided to hospitals and physicians. This financial support to currently non-incentivized providers in post acute care settings should include monetary incentives such as small business loans, tax incentives, grants from the Medicare and Medicaid programs, partnerships with hospitals and physician practices and other technology pass-through support.

RATIONALE: In order to participate in the goal of implementing EHRs by 2014, HHAs and hospices will require financial assistance to purchase the necessary systems and adopt new certified electronic health information technologies. Current reimbursement standards under Medicare, Medicaid, and other payers do not provide the capital foundation for such purchases.

ESTABLISH STABILITY AND EQUITY AMONG MEDICARE HEALTH CARE PROVIDERS IN APPLICATION OF THE WAGE INDEX

ISSUE: Since the inception of the Medicare per visit cost limits, home health payment rates have been adjusted to reflect varying wage levels across the nation through the application of a wage index. This payment rate adjustment continues under the Medicare home health prospective payment system (PPS), which was implemented October 1, 2000. However, the wage index that has been utilized by the Centers for Medicare & Medicaid Services (CMS) has been based upon wages within hospitals across the nation. This index is derived from data that explicitly excludes any home health services costs. An attempt some years back to create and utilize a home health-specific wage index failed due to the unavailability of reliable wage data. The hospice wage index also is based upon hospital wage data.

While the home health payment rates are based upon the application of a hospital wage, the index utilized and its manner of application is significantly distinct from that utilized relative to hospital services payment rates. Of particular concern is the fact that a hospital may secure a geographic reclassification for application of the wage index by establishing that the hospital draws on an employment pool different from the geographical area to which it would otherwise be assigned for its wage index level. Home health agencies and hospices are not authorized to secure a wage index reclassification. As a result, a hospital may compete for the same health care employees as a hospice or home health agency but be approved for a relatively higher payment rate through the wage index reclassification. Additionally, Congress has established specific wage index criteria for certain geographic locations. However, these criteria apply only to hospitals. Hospitals also are provided extra protection against losses due to dramatic drops in their wage indices by a provision imposing a “rural floor” under which no hospital’s wage index can fall below the state-specific rural wage index.

Finally, home health agencies and hospices are not afforded any type of stop-loss protections. As a result, changes in area wage indices from year to year are sometimes dramatic, and always difficult to plan for. For example, in recent years one area of Texas underwent a 12 percent drop in its wage index value one year, and a 14 percent increase the next year.

On a related note, concerns are on the rise that the home health PPS case-mix adjuster has proven difficult to refine sufficiently so that agencies are appropriately reimbursed for care. Refinement to the home health wage index calculation method could help in this regard.

During 2007 the Medicare Payment Advisory Commission (MedPAC) recommended to Congress that it give authority to the Secretary of the Department of Health & Human Services to fashion a new system for calculating the wage index for hospitals as well as several other providers, including home health. MedPAC’s recommendation would base the wage indices for all providers on a different data set than the one currently in use by Medicare. In doing so, it also would eliminate any need for geographic reclassifications and the rural floor.

The Patient Protection and Affordable Care Act provides for comprehensive reform of the Medicare hospital wage index system that takes into account MedPAC’s 2007 recommendations (PPACA Section 3137). This provision requires that CMS submit a report to Congress by December 31, 2011, setting out a plan to reform the wage index consistent with the 2007 MedPAC recommendations.

RECOMMENDATION: Congress should authorize Medicare to implement and apply a wage index model in line with the system recommended by MedPAC no later than 2013. Otherwise, Congress should allow hospices and home health agencies to obtain a geographic reclassification for wage index purposes in a manner comparable to that available to the hospitals or to allow reclassifications automatically

when a hospital in the geographic locale of the hospice or home health agency receives a reclassification. Additionally, Congress should enact legislation that limits a home health agency's loss of income due to a dramatic shift in the agency's wage index (for example, limit the drop in any agency's wage index from one year to the next to 2 percent). Finally, Congress should extend to all providers protections that ensure that no entity's wage index falls below the rural wage index value in that state.

RATIONALE: In today's health care environment, health care providers of all types compete for employment of the same personnel. The adjustment of Medicare payment rates intended to reflect variations in wages across the nation should be consistent across all provider types. With increasing shortages of health care personnel, unequal wage index adjustments for health care providers in the same geographic region results in an uneven and discriminatory distribution of the employment pool of personnel. Further, in recent years some agencies have experienced dramatic increases and drops in their wage indices. This degree of "swing" in reimbursement can have a significant impact on an agency's financial viability.

ENACT HOME CARE AND HOSPICE SPECIFIC ANTI-FRAUD MEASURES

ISSUE: Home care and hospice, like all industries, is not immune to the presence of participants who engage in improper and illegal schemes for the sake of profit. At the same time, health care providers that operate well within the law are unable to effectively compete in the market when faced with competitors that offer kickbacks for patient referrals, bill for services not provided, or charge costs that are not part of the delivery of services.

The Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, contains a number of program integrity measures that are home care and hospice specific or are permitted to be implemented in home care or hospice. These include:

- Moratorium authority on new providers
- Mandatory compliance plans
- Background screening of caregivers
- Credentialing of provider management
- Physician face-to-face encounter requirement prior to certification of care need or for recertification of terminal status in hospice
- Physician enrollment requirement for care certification

The PPACA changes will go a long way to improve program integrity in Medicare and Medicaid. However, the home care and hospice communities believe that more can be done. Additional steps could include:

- Focused credentialing standards for owners and management including competency testing
- Requiring an expedited quality of care survey in the event of a change in ownership of an HHA or hospice within 2 months of the change in ownership
- Establishment of a Joint Program Integrity Council designed to bring insight and innovation into program integrity efforts with representation from all stakeholders.

RECOMMENDATION: Congress should continue its work in combating waste, fraud, and abuse in our nation's health care system by supporting the Centers for Medicare and Medicaid Services in implementing the reforms enacted through PPACA and by passing additional measures that include:

- The institution of corporate compliance plans by all home health agencies and hospices to ensure adherence to all federal and state laws with proper funding support.
- Mandatory screening and federally-funded background checks on all individuals wishing to open a Medicare home health agency or hospice as well as all employees of home health agencies and establishment of a national registry of home care workers consistent with existing state laws.
- Strengthening of program participation standards to include experience credentialing and competency testing of home health agency or hospice personnel responsible for maintaining compliance with Medicare standards; such as the Certified Home Care Executive (CHCE), credentialing available through the National Association for Home Care & Hospice (NAHC).
- The investment of sufficient government and industry resources to expedite refinements to the Medicare payment systems so that providers are appropriately reimbursed for the costs of providing services.
- Providing consumers and prospective consumers of Medicare home health services and hospice care with a summary of program coverage requirements. The consumer reporting hotline for suspected fraud, waste, and abuse also should be enhanced and made more accessible.
- Implementation and development of credentialing and competency testing standards for government contractors and federal regulators responsible for issuing Medicare determinations.

A hotline should be developed for beneficiaries and providers to report inadequate enforcement action by those charged with protecting Medicare and Medicaid.

- Supplying adequate administrative financing to Medicare/Medicaid to enforce existing laws and regulations such as survey and certification standards, provider education, and claims reviews.
- Enhancement of education and training of home health agency and hospice staff through joint efforts with regulators.
- Implementation of outcome-based compliance standards that provide operational flexibility and also eliminate structural requirements that are unrelated to the provision of high quality Medicare home health services or hospice care.
- Development and implementation of Medicare coverage and reimbursement standards in language that is understandable and accessible to providers and consumers through various means; for example, through the Internet, federal depository libraries, and fiscal intermediaries.
- The establishment of a Joint Program Integrity Advisory Council.

RATIONALE: It is particularly important to ensure that limited health care dollars go to the provision of patient care rather than being diverted into the pockets of unscrupulous providers. A comprehensive fraud and abuse package that includes home health and hospice specific provisions and provides adequate enforcement tools to punish those who willfully and knowingly defraud the system is needed.

Moreover, any anti-fraud legislation must make a distinction between willful fraudulent activity and unintentional failure to comply with Medicare regulations. For example, the Office of the Inspector General often characterizes as fraud technical errors on claims or billing for services that the need for which is not documented sufficiently to demonstrate that it meets Medicare reimbursement requirements related to medical necessity. In such cases, provider education may be a more appropriate response than more punitive measures.

